

DECLARATION OF INCOME

Personally identifiable information on this form is collected to determine your share of the cost of services for the Birth-3, Family Support or Community Options Programs and will be used only for this purpose.

1. What is the total number of persons in the family who depend on your combined family income? _____
2. Of these, how many people have a disability or participate in the Birth-3 program? _____
Name: _____ Birthdate: _____
(mm/dd/yyyy)
Name: _____ Birthdate: _____
Name: _____ Birthdate: _____
3. Check the programs which client or parent is eligible for. ☐ W-2 ☐ SSI or SSI-E ☐ Food Stamps
NOTE: If you checked any program above, you do not need to fill out the rest of this form. Sign and date on the back.
4. What is the annual income of your child(ren) with disabilities? \$ _____
NOTE: If the child with disabilities is 18 years or older, you do not need to fill out the rest of this form. Sign and date on the back.

IF THE ELIGIBLE CHILD IS UNDER 18, answer the following questions on family income.

5. List the family's annual adjusted gross income (line 33 of U.S. Form 1040). * \$ _____
List the amount from 20a and 20b of U.S. Form 1040. \$ _____ \$ _____
(20a) (20b)

*If Form 1040 does not closely approximate your expected income for the coming year, make an estimate of your total family earned and unearned income. Be sure to include income from the following sources:

| | | | |
|------------------------|----------|--------------------|----------|
| Salaries, wages, etc.: | \$ _____ | Dividends: | \$ _____ |
| Net business: | \$ _____ | Pensions: | \$ _____ |
| Social Security: | \$ _____ | Interest: | \$ _____ |
| Child support: | \$ _____ | Net rental income: | \$ _____ |
| Alimony: | \$ _____ | Other: | \$ _____ |
| TOTAL INCOME: | \$ _____ | | |

6. List the amount of income reported above that is contributed by a stepparent. \$ _____
7. List the court ordered annual total if you pay: Alimony – \$ _____ Child support – \$ _____
8. If you have other children who receive social security or other benefits, or if you receive adoption subsidy payments, list the total annual amount received: \$ _____
9. If you have rental, self-employed or farm income, list depreciation claimed for those incomes.
(See Schedule C, Schedule E, and / or Schedule F) \$ _____
10. List the annual amount of actual principal payments on business, farm or rental property.
(From bank statement.) \$ _____

11. What amount is your family paying annually **for care and services related to the special needs or disability of your child?** These are costs you anticipate paying out-of-pocket during the year in which services are provided that you would not ordinarily pay if your child did not have special needs. You may use actual dollar amounts paid during the past year as **a basis to estimate** costs in the coming year, if the costs are expected to continue. Estimates may be reviewed against actual out-of-pocket costs at the end of the year and adjusted accordingly.

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|--|----------|
| a. Payments to physicians, dentists, therapists, and other medical professionals, child's insurance premium and deductible, co-payments and payments for child's past medical bills. | \$ _____ |
| b. Long distance phone calls for related medical needs. | \$ _____ |
| c. Equipment, supplies, and over-the-counter drugs, not covered by insurance or Medical Assistance. | \$ _____ |
| d. Amounts paid to modify home or vehicle for accessibility. | \$ _____ |
| e. Transportation costs for medical or respite at \$ _____ per mile. | \$ _____ |
| f. Differences between regular child care rates and what parents pay for their child with special needs, full child care costs for children 12 years and older. | \$ _____ |
| g. Parent training workshops, periodicals and books related to the child with disabilities. | \$ _____ |
| h. Specialized clothing. | \$ _____ |
| i. Specialized nutrition. | \$ _____ |
| j. Respite services. | \$ _____ |
| k. List item and cost of any other expenses related to the child's disability or special needs. | |
| _____ | \$ _____ |
| _____ | \$ _____ |
| _____ | \$ _____ |
| TOTAL (11a – 11k) | \$ _____ |

12. Are you paying for services currently being provided to any family members under the Uniform Fee System? (Examples are social services and community board services such as mental health services.) What is the amount?

\$ _____

I have tried to give true and accurate information in this declaration. I understand that the Agency may request more detailed and documented information at a later time.

SIGNATURE – Parent or Guardian

Date Signed